DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 7/14/13

PRINTED: 06/03/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	44E200	A. BUILDING _____ B. WING _____	05/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELBROOK SANITARIUM	114 CAMPUS DRIVE DAYTON, TN 37321

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F 170 SS=D	483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, and interview, the facility failed to ensure the resident's rights of privacy by opening mail of one resident, #8, of twenty-four residents reviewed. The findings included: Medical record review of the quarterly Minimum Data Set (MDS), dated March 28, 2013, revealed a Brief Interview for Mental Status (BIMS) score of 15 (15 equals congitively intact). Review of the facility policy "Resident Rights" revealed "...laws guarantee certain basic rights to all residents of this facility...include the resident's right to:...h. Privacy in sending and receiving mail..." Interview with resident #8, on May 30, 2013, at 10:30 a.m., in the resident room, revealed "... (Social Worker) opens the mail, I never get anything that isn't opened, my son in Oklahoma sends me money and (Social Worker) always opens it and looks to see if he sent me money..." Interview with the Social Worker in the Restorative room, on May 30, 2013, at 10:45	F 170	**F 170 483.10(i)(1) RIGHT TO PRIVACY-SEND/RECEIVE UNOPENED MAIL** The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened Resident #8 1) On 5/30/13 the Administrator communicated to all nursing staff (RN, LPN, CNA), Social Services, Activities, Restorative, and Business Office that Resident #8 does not want her mail opened. On 5/30/13 the Administrator reviewed & revised the policy for identifying residents request for handling their mail-the Admission Resident Agreement and Resident Rights. (Exhibit #2) On 6/10/13 & 6/11/13 the Director of Nursing (DON) conducted a mandatory in-service for all nursing staff (RN, LPN, CNA), Dietary, Business office, Social Services, Activities, Restorative, Housekeeping, Laundry, and	6/11/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Keith Will — TITLE: Administrator — (X6) DATE: 6/14/13

...ficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ...other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ...ollowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ...days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ...program participation.

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			Therapy concerning opening mail and resident rights. (Exhibit #1) Any staff not attending mandatory in-services will not be allowed to work until they have attended the in-service. 2) On 6/3/13 & 6/4/13 the Social Service Director conducted a survey with residents or resident's POA to identify who wants their mail opened or not opened. The survey questions were the same questions used on the Admission Resident Agreement form. (Exhibit # 2) Upon completion of survey the results were placed on the resident's care plan & communicated to all staff at the mandatory in-services conducted on 6/10/12 & 6/11/13 by the DON. 3) To ensure the deficient practice does not recur, the revised Resident Admission Agreement will be used for all new admissions to the facility beginning 6/3/13 for correct documentation of handling	

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			resident mail. If any errors or omissions are found, the responsible staff member will be notified within 24 hours and disciplinary action imposed. Beginning 6/10/13 the Social Service Director will maintain a list of residents who want assistance and those who do not want assistance or those with special requests. The list will be maintained by the Social Services Director who will be responsible for any changes to the list. This process will continue indefinitely. 4) Beginning 6/14/13 the administrator will monitor for 3 months & then quarterly for 12 months for proper handling of resident mail by staff. These findings will be reported at the next quarterly QAPI committee meeting scheduled for July 8, 2013. The administrator will report to the Governing Body concerning these monitoring outcomes at the next Governing Body meeting.	

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F 170	Continued From page 1 a.m., confirmed the mail is opened for residents that are not physically able to open mail, not mentally able to open mail and if it is an "EOB (explanation of benefits), or something to that affect" that needs to be placed in the resident file. Interview with the Administrator on May 30, 2013, at 12:45 p.m., in the hallway, confirmed the mail is to be delivered to the residents unopened.	F 170		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview,	F 280	**F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP** The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. 1) On 6/5/13 the DON conducted a one on one in-service with the MDS nurse who is responsible for updating care plans when interventions change and informing nurses (RN, LPN, CNA) of changes within 24 hours. (Exhibit # 5) On 6/7/13 the DON in-serviced the nursing charge nurses & supervisors concerning their responsibility for ensuring care plans have the current fall interventions.	6/11/13

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F 280	Continued From page 2 the facility failed to update the resident's comprehensive care plan falls for one resident (#25) of twenty-four residents reviewed. The finding included: Resident # 25 was admitted to the facility on January 30, 2012, with diagnoses of Anemia, Hypertension, End Stage Renal Disease, Cerebrovascular Accident, Anxiety, and Depression. Medical record review revealed the resident had falls on: August 17, 2012, August 27, 2012, September 7, 2012, November 10, 2012, November 27, 2012, December 23, 2012 , and May 1, 2013, with interventions of "...encourage the resident to call for assistance when in bathroom, enhanced safety observation, assist to bathroom after meals, staff education, keep room free of clutter/obstructions daily, increase level of observation, chair alarm, bed alarm, staff in service on placement of chair alarm, patient placed in rehab program. Specify type...Restorative, staff member to always push wheelchair or Geri chair, when taking to bus..." Medical record review of the resident's Comprehensive Care Plan for falls, reviewed on January 30, 2013, revealed no documentation for the above listed fall interventions from August 17, 2012, through May 1, 2013. Interview with care plan coordinator Licensed Practical Nurse (LPN) #2, on May 30, 2013, at 10:30 a.m., on the back terrace gazebo, confirmed the care plan for falls had not been updated with the interventions initiated after the	F 280	On 6/10/13 & 6/11/13 the Director of Nursing (DON) conducted a mandatory in-service for all nursing staff (RN, LPN, CNA) concerning communication of care plan changes. (Exhibit # 1) Any staff not attending mandatory in-services will not be allowed to work until they have attended the in-service. 2) On 6/5/13 & 6/6/13 the DON & MDS nurse reviewed the care plans of those residents who had fall over the past 6 months to ensure the interventions were listed on the care plans. There were no other residents found with fall intervention not on care plan. (Exhibit # 7)	

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			3) Beginning 6/3/13, the DON will be responsible for investigating all incidents including falls and writing interventions on the Post Fall Investigation form. A copy of the Investigation form will be provided to the MDS nurse to put on the resident's care plan and communicated to the nursing staff within 24 hours. To ensure the deficient practice does not recur, the DON or supervisor will monitor care plans with fall interventions for 6 months until substantial compliance has been obtained. 4) Beginning 6/13/13, the DON will report monitoring outcomes monthly to the Administrator until compliance is reached, and report outcomes quarterly to QAPI Committee. The next QAPI meeting is scheduled for July 8, 2013. The Administrator will report outcomes at the next Governing Body meeting.	

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F 280	Continued From page 3 fall investigations.	F 280		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to ensure a dependent resident's food (resident #3) was swallowed after a meal of twenty-four residents reviewed. The findings included: Resident #3 was admitted to the facility on October 22, 2010, with diagnoses including Severe Schizophrenia, Psychosis, Seizure Disorder, Diabetes Mellitus, History of Nausea and Vomiting, and Peg tube placement. Medical record review of a quarterly minimum data set dated May 2, 2013, revealed extensive assistance with eating required. Observation on May 29, 2013, at 8:50 a.m., revealed resident asleep in bed with mouth open with visible food on the resident's tongue. Continued observation revealed all the breakfast carts had been removed from the hall and no staff were observed around the resident's room.	F 312	**F 312 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS** A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. 1) Upon be made aware of the deficient practice on 5/29/13, the LPN charge nurse immediately removed the food particle from resident # 3's mouth and provided oral hygiene. On 6/4/13 the DON conducted one on one in-service with the staff feeding resident #3 concerning checking resident's mouth for retained food after feeding their meals. On 6/10/13 & 6/11/13 the Director of Nursing (DON) conducted a mandatory in-service for all nursing staff (RN, LPN, CNA) concerning checking resident's mouth for retained food after feeding. (Exhibit # 8)	6/11/13

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			Any staff not attending mandatory in-services will not be allowed to work until they have attended the in-service. 2) Beginning 6/4/13 the DON &/or Supervisor checked all residents who were dependent on being fed to ensure residents had swallowed all their food. This was done until 6/11/13. 3) Beginning 6/13/13 the DON &/or supervisor will check all dependent residents at least 1 meal per week to ensure residents are swallowing their food. If a resident is found with food in their mouth, the assigned CNA or feeding tech will be disciplined immediately and re in-serviced.	

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			4) Beginning 6/13/13, the DON will report monitoring outcomes monthly to the Administrator until compliance is reached, and report outcomes quarterly to QAPI Committee. The next QAPI meeting is scheduled for July 8, 2013. The Administrator will report outcomes at the next Governing Body meeting.	

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F 312	Continued From page 4 Interview and observation on May 29, 2013, at 8:53 a.m., with Licensed Practical Nurse (LPN) #3 confirmed the staff had failed to ensure the resident had swallowed all the food.	F 312	**F 314 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES**	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on medical record review, and interview, the facility failed to provide care by not administering vitamins and minerals to promote the healing of a pressure sore for one (#43) resident with a stage II pressure ulcer of twenty-four residents reviewed. The findings included: Resident #43 was admitted to the facility on January 9, 2013, with diagnoses including Dementia, Diabetes, Failure To Thrive-Adult, and Hypertension. The resident expired at the facility on February 7, 2013. Medical record review of the Wound Assessment Worksheet dated January 17, 2013, revealed "...both side of coccyx...stage II Length 1 cm	F 314	**Resident #43** 1) On 6/3/13 the DON conducted a one on one in-service with the nurses who assessed the wound on 1/17/13 and the nurse who wrote the order on 1/19/13 but failed to transcribe orders to the MAR resulting in failure of medications not being given. (Exhibit #9) On 6/7/13 the DON reviewed and revised the Current Wound Care Protocol that eliminates lab and medications at any wound stage. The change provides the MD to order labs or medications when he is notified of changes in the wound. (Exhibit #10) On 6/3/13, the DON reviewed the 24 hrs chart check policy and will continue with the 24 hour chart check	6/11/13

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			implemented 3/19/13 for checking all charts for written orders in the past 24 hours. This policy and process will be re-reviewed with the nursing staff (RN and LPN) on 6/10/13 & 6/11/13 by the DON. (Exhibit #11) On 6/3/13, the DON reviewed & decided to continue the process for a second nurse check on written physician orders that was implemented 3/19/13. The second nurse will check the first nurse's work on the written order to ensure order was written accurately and transcribed correctly to MAR, requisition completed, fax to pharmacy, etc. This policy and process will be re-reviewed with the nursing staff (RN and LPN) on 6/10/13 & 6/11/13 by the DON. On 6/10/13 & 6/11/13 the Director of Nursing (DON) conducted a mandatory in-service for all nursing staff (RN, LPN, CNA) concerning transcribing physician orders , 24 hour Chart Check, Second	

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			nurse check on physician. orders and change in Wound Care Protocol. Any staff not attending mandatory in-services will not be allowed to work until they have attended the in-service. Effective 6/14/13 the new electronic medication system is scheduled to go live. The company began educational training on 5/13/13 with implementation in June. The new EMR system will eliminate paper orders and paper MARs. Documentation will be electronic. 2) Beginning 6/4/13 the DON & Supervisor checked all resident's chart for any missed orders for the past 3 months. There were no residents with missed orders. 3) To ensure the deficient practice does not recur, the DON &/or Supervisor will begin on 6/13/13 checking all written orders daily for 4 weeks, then a	

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			random sample monthly for any missed orders. If any errors or omissions are found, the responsible staff member will be notified within 24 hours and disciplinary action imposed. Beginning 6/13/13 the Consultant Pharmacist will also monitor for any missed orders or transcribing errors monthly and report to the DON the outcomes of the monitoring. 4) Beginning 6/13/13, the DON will report monitoring outcomes quarterly to QAPI Committee. The next QAPI meeting is scheduled for July 8, 2013. The Administrator will report outcomes at the next Governing Body meeting.	

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F 314	Continued From page 5 (centimeter) Width 3.5 cm...Drainage...none..." Medical record review of the physician's orders dated January 19, 2013, revealed "...Vit (Vitamin) C 500mg (milligrams) po (by mouth) BID (twice a day) x 2 weeks. Zinc 200mg po QD (everyday) x 2 weeks. Multivitamin QD x 2 weeks..." Medical record review of the Medication Administration Record dated January, 2013, and February, 2013, revealed no documentation the Vitamin C, Zinc, or Multivitamin had been administered. Medical record review of the Wound Assessment Worksheet dated January 29, 2013, revealed "... (left and right) buttocks...stage II...#1 L-(length) 0.7 (centimeters) W (width)-0.3 (centimeters)... (no drainage)..." Interview on May 30, 2013, at 8:45 a.m., with the Director of Nursing (DON), in the DON's office, confirmed the Vitamin C, Zinc, and Multivitamin had not been administered as ordered by the Nurse Practitioner.	F 314		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325	**F 325 483.25(i) MAINTAIN NUTRITIONS STATUS UNLESS UNAVOIDABLE** Based on a resident's comprehensive assessment, the facility must ensure that resident -1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible, and 2) Receives a therapeutic diet when there is a nutritional problem.	6/18/13

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F 325	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to ensure consistent monitoring of meal intake and administration of tube feeding for one resident (#3) of twenty-four residents reviewed. The findings included: Resident #3 was admitted to the facility on October 22, 2010, with diagnoses including Severe Schizophrenia, Psychosis, Seizure Disorder, Diabetes Mellitus, History of Nausea and Vomiting, and Percutaneus Feeding Tube (PEG) placement. Medical record review of the resident's Care Plan onset date December 14, 2010, revealed "...Problem Obesity...Goal...will remain at current weight or below...Approach...Praise (resident) efforts to stay on diet..." Continued review of the resident's Care Plan onset date January 27, 2012, revealed "...Problem...Gastrostomy Tube: Resident refuses PO (by mouth) intake, may use PEG Tube for all meals and medications..." Medical record review of the Physician Recapitulation orders dated May 1, 2013, revealed resident weights March 2013, 162 LBS(pounds), April 2013, 156 LBS. Continued review of the Recapitulation orders revealed "...February 27, 2013 (original date of order)...Jevity 1.5 CAL (calorie) PEG tube TID (three times a day) PRN (as needed) give if eats less than 25 % of meal..."	F 325	Resident # 3 1) Beginning 6/3/13 and continuing every day, the DON &/or Supervisor had one on one in-services with 7-3& 3-11 CNAs and feeding techs on documentation of meal intake until all CNAs & feeding techs were in-serviced. Beginning 6/13/13 the charge nurses on the day and evening shifts will check documentation of each CNAs documentation of meal percentage and if not completed, CNA must complete before he/she can go home. If a CNA consistently fails to record the meal percentage > than 3 times per week he/ she will be reported to the DON for disciplinary action and re in-serviced.	

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			On 6/10/13 & 6/11/13 the Director of Nursing (DON) conducted a mandatory in-service for all licensed nursing staff (RN, LPN) concerning recording tube feedings on the MAR and the policy on documentation of medications. Any staff not attending mandatory in-services will not be allowed to work until they have attended the in-service. Effective 6/14/13, the new electronic medication system purchased by facility will go live. The company staff began educational training on 5/13/13 with implementation in June. The new EMR system will not allow nurses to leave blanks on the MAR. It will also be easier to check for documentation of meal percentages.	

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			2) Beginning 6/13/13 the DON & Supervisor checked all resident's chart for any missed documentation on meal percentages and tube feeding and medications not documented. There were no residents with missed meal percentages or missed tube feeding or medication documentation. These checks will be conducted daily for 4 weeks, then randomly on a monthly basis. 3) To ensure the deficient practice does not recur, the DON &/or Supervisor will begin on 6/13/13 checking documentation daily for 4 weeks, then a random sample monthly for any omission of documentation of percentage of meals and documentation of tube feeding & medications. If any errors or omissions are found, the responsible staff member will be notified within 24 hours and required to return to facility to correct the	

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			documentation. Continued deficient practice will be disciplined by the DON. Beginning 6/13/13 the Consultant Pharmacist will also monitor for any missed documentation of medications monthly and report to the DON the outcomes of the monitoring. 4) Beginning 6/13/13, the DON will report monitoring outcomes quarterly to QAPI Committee. The next QAPI meeting is scheduled for July 8, 2013. The Administrator will report outcomes at the next Governing Body meeting.	

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F 325	Continued From page 7 Medical record review of the resident's Daily Meal Intake Report for March 2013 and April 2013 revealed fifty of sixty days with incomplete documentation of the resident's intake. Medical record review of the resident's Medication Administration Record for March 2013 and April 2013, revealed only seventeen days the Jevity 1.5 cal was documented as administered through the tube. Medical record review of a Dietary assessmnet dated May 22, 2013, revealed "...Resident's eatin (eating) varies. Nausea and vomiting occuring more often..." Observation of the resident on May 30, 2013, at 8:53 a.m., in the resident room, with Certified Nursing Assistant (CNA) #1 and CNA #2 revealed resident's current weight was 139 pounds. Interview with the Physician and the Director of Nursing (DON) in the social services office, on May 30, 2013, at 10:58 a.m., revealed the Physician was aware of the resident's weight loss and the resident was still within ideal body weight range (IBW) of 127-141 pounds. Continued interview with the Physician revealed he/she was aware of the resident persistant nausea and vomiting and that gallbladder concerns had been ruled out as a possible cause. Interview and medical record review on May 30, 2013, at 1:15 p.m., with the DON confirmed the facility failed to consistently monitor/document the resident's meal intake and administration of the tube feeding.	F 325		
F 372	483.35(l)(3) DISPOSE GARBAGE & REFUSE	F 372		

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			F 372 483.35(l)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. 1) Upon be made aware of the deficient practice on 5/28/13, the Dietary Manager immediately arranged the trash in the dumpsters so lid would close. On 6/4/13 the Dietary Manager conducted one on one in-service with the staff taking trash out on 5/28/13 on the proper method of disposal of trash. On 6/10/13 & 6/11/13 the Dietary Manager conducted a mandatory in- service for all Dietary staff concerning proper disposal of trash and closer of dumpster lid at all times. Any staff not attending mandatory in-services will not be allowed to work until they have attended the in-service.	6/11/13

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			2) Beginning 6/13/13 the Dietary Manager created a check list for a daily check of the dumpster to ensure the lid is closed. This assignment will be given to one dietary staff on a weekly basis. Any improper disposal will be corrected immediately and reported to the Dietary Manager of findings. 3) To ensure the deficient practice does not recur, the Dietary Manager will begin on 6/13/13 checking documentation daily for 4 weeks. If any errors or omissions are found or reported, the responsible staff member will be re-in-serviced and if continued deficient practice will be disciplined by the Dietary Manager. 4) Beginning 6/13/13, the Dietary Manager will report monitoring outcomes quarterly to QAPI Committee. The next QAPI meeting is scheduled for July 8, 2013. The Administrator will report outcomes at the next Governing Body meeting.	

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F 372 SS=C	Continued From page 8 PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure garbage and refuse were disposed of properly. The findings included: Observation and interview with the Dietary Manager on May 28, 2013, at 10:58 a.m., revealed three outside dumpsters with trash exposed. Continued interview with the dietary manager confirmed the dumpster lids are to be kept closed.	F 372		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441	**F 441 483.65 INFECTION CONTROL PREVENT SPREAD, LINENS** The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection Resident #28 1) Upon being made aware of the deficient practice on 5/28/13, the LPN charge nurse immediately changed the oxygen tubing and humidifier bottle. On 6/10/13 & 6/11/13 the Director of Nursing (DON) conducted a mandatory in-service for all nursing staff (RN, LPN, CNA) concerning the Oxygen policy and checking oxygen tubing and humifier for need to change. Any staff not attending mandatory in-services will not	6/11/13

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F 441	Continued From page 9 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, facility policy review, and interview, the facility failed to maintain the oxygen tubing and humidifier bottle in a sanitary manner for one resident, #28, of twenty- four residents reviewed. The findings included: Resident #28 was admitted to the facility on January 30, 2013, with diagnoses of Altered Mental Status, Diabetes Mellitus, Hypertension, Renal Failure, and Anemia. Observation on May 28, 2013, at 10:45 a.m., in	F 441	be allowed to work until they have attended the in-service. On 6/9/13 the DON revised the Administration of Medication to include the evaluation of Oxygen tubing and humifier on a scheduled basis and to be recorded on the MAR. The DON will in-service this revision of the Administration of Medication policy at the mandatory meeting on 6/10/13 & 6/11/13. 2) Beginning 6/4/13 the DON &/or Supervisor checked all residents who werereceiving Oxygen for any needed 02 tubing &/or humifier changes to ensure residents had clean equipment. 3) To ensure the deficient practice does not recur, the DON &/or Supervisor will begin on 6/13/13 checking documentation on MAR and nurses notes for changes in oxygen tubing or humifier on a weekly basis for 8 weeks, then a random monthly sample for any oxygen tubing not changed	

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			when needed. If any errors or omissions are found, the responsible staff member will be notified within 24 hours and staff member will be required to report to DON why changes were not done. Continued deficient practice will be disciplined by the DON. 4) Beginning 6/13/13, the DON will report monitoring outcomes quarterly to QAPI Committee. The next QAPI meeting is scheduled for July 8, 2013. The Administrator will report outcomes at the next Governing Body meeting.	

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F 441	Continued From page 10 the resident's room, revealed the resident's nasal cannula tubing and humidifier and had a build-up of debris, and were dated April 11, 2013 Review of facility policy "USE OF OXYGEN" revealed "...The 02 (oxygen) cannula or mask does not require scheduled changing when used on one resident. It should be changed when soiled or dirty. 02 Cannulas or masks will be checked every 14 days for needed changing..." Review of the Respiratory Equipment check sheet revealed no documentation the cannula had been checked since April 17, 2013. Interview with Licensed Practical Nurse (LPN) #1 , in the resident's room on May 28 ,2013, at 10:48 a.m., confirmed the tubing and humidifier bottle was not clean and was dated April 11, 2013, and "... should have been changed..."	F 441		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to obtain laboratory services for two residents (#32, #43) of twenty-four residents reviewed. The findings included: Resident #32 was admitted to the facility on	F 502	**F 502 483.75(j)(1) ADMINISTRATION** The facility must provide or obtain laboratory services to meet the needs of the residents. The facility is responsible for the quality and timeliness of the services. Residents # 32 & #43 1) On 6/3/13 the DON conducted a one on one in-service with the phlebotomist	6/14/13

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			who failed to draw blood on 5/10/13 for TSH on Resident # 32 and the nurse who wrote the order for Albumin on 1/19/13 for resident # 43 but failed to order lab resulting in failure of lab being drawn. (Exhibit #12) On 6/3/13, the DON reviewed the 24 hrs chart check policy and will continue with the 24 hour chart check implemented 3/19/13 for checking all charts for written orders in the past 24 hours. This policy and process will be re-reviewed with the nursing staff (RN and LPN) on 6/10/13 & 6/11/13 by the DON. On 6/3/13, the DON reviewed & decided to continue the process for a second nurse check on written physician orders that was implemented 3/19/13. The second nurse will check the first nurse's work on the written order to ensure order was written accurately and transcribed correctly to MAR, requisition completed, fax to pharmacy, given to phlebotomist, etc. This	

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			policy and process will be re-reviewed with the nursing staff (RN and LPN) on 6/10/13 & 6/11/13 by the DON. On 6/7/13 the DON reviewed the revised Lab monitoring log to include the returned lab results on 3/19/13 and decided to continue using the lab log to assist in monitoring ordered lab test. On 6/7/13 the DON decided to continue with the following process put in place on 3/19/13 to add ordered lab to the MAR so nurse must initial the square on date of draw which serves as a reminder to check for lab results. On 6/10/13 & 6/11/13 the Director of Nursing (DON) conducted a mandatory in-service for all nursing staff (RN, LPN, CNA) concerning transcribing physician orders , 24 hour Chart Check, Second nurse check on physician. orders and checking lab log to	

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			ensure the lab was drawn and results returned. Any staff not attending mandatory in-services will not be allowed to work until they have attended the in-service. Effective 6/14/13, the new electronic medication system purchased by facility will go live. The company staff began educational training on 5/13/13 with implementation in June. The new EMR system will eliminate paper orders and paper MARs. Documentation will be electronic. Monitoring lab orders can be done electronic on a weekly or daily basis. 2) Beginning 6/4/13 the DON & Supervisor checked all resident's chart for any missed lab orders for the past 3 months. There were no residents with missed orders. 3) To ensure the deficient practice does not recur, the DON &/or Supervisor will begin on 6/13/13 checking all written	

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	44E200	A. BUILDING _____ B. WING _____	05/30/2013

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			orders daily for 4 weeks, then a random sample monthly for any missed orders of any kind. If any errors or omissions are found, the responsible staff member will be notified within 24 hours and disciplinary action imposed. 4) Beginning 6/13/13, the DON will report monitoring outcomes quarterly to QAPI Committee. The next QAPI meeting is scheduled for July 8, 2013. The Administrator will report outcomes at the next Governing Body meeting.	

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F 502	Continued From page 11 September 21, 2012, with diagnoses including Hypothyroidism, Cellulitis, Diabetes, Congestive Heart Failure, and Atrial Fibrillation. Medical record review of a Nurse Practitioner's order dated April 10, 2013, revealed "...TSH (laboratory test for Thyroid Stimulating Hormone) this month..." Medical record review revealed no documentation the TSH had been completed. Interview on May 29, 2013, at 2:50 p.m., with the Director of Nursing, in the Social Services office, confirmed the TSH had not been completed. Resident #43 was admitted to the facility on January 9, 2013, with diagnoses including Dementia, Diabetes, Failure To Thrive-Adult, and Hypertension. The resident expired at the facility on February 7, 2013. Medical record review of the physician's orders dated January 19, 2013, revealed "... Check Albumin level and if low (less than) (3.5), start protein powder 2 scoops daily x 2 weeks..." Medical record review revealed no laboratory results for the Albumin level. Interview on May 30, 2013, at 8:45 a.m., with the Director of Nursing (DON), in the DON's office, confirmed the Albumin level had not been obtained as ordered by the Nurse Practitioner.	F 502		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	F 514	**F 514 483.75(l)(1) RESIDENT-COMPLETE/ACCURATE/ACCESSIBLE** The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.	6/14/13

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F 514	Continued From page 12 The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to ensure the medical record was accurate for the monitoring of meal intake and administration of tube feeding for one resident (#3) of twenty-four residents reviewed. The findings included: Resident #3 was admitted to the facility on October 22, 2010, with diagnoses including Severe Schizophrenia, Psychosis, Seizure Disorder, Diabetes Mellitus, History of Nausea and Vomiting, and Percutaneus Feeding Tube (PEG) placement. Medical record review of the resident's Care Plan onset date December 14, 2010, revealed "...Problem Obesity...Goal...will remain at current weight or below...Approach...Praise (resident) efforts to stay on diet..." Continued review of the resident's Care Plan onset date January 27,	F 514	Resident #3 1) Beginning 6/3/13 and continuing every day, the DON &/or Supervisor had one on one in-services with 7-3& 3-11 CNAs and feeding techs on documentation of meal intake until all CNAs & feeding techs were in-serviced. Beginning 6/13/13 the charge nurses on the day and evening shifts will check documentation of each CNAs documentation of meal percentage and if not completed, CNA must complete before he/she can go home. If a CNA consistently fails to record the meal percentage > than 3 times per week he/ she will be reported to the DON for disciplinary action and re in-serviced. On 6/10/13 & 6/11/13 the Director of Nursing (DON) conducted a mandatory in-service for all licensed nursing staff (RN, LPN) concerning recording tube feedings on the MAR and the policy on documentation of medications. (Exhibit # 11)	

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F 514	Continued From page 13 2012, revealed "...Problem...Gastrostomy Tube: Resident refuses PO (by mouth) intake, may use PEG Tube for all meals and medications..." Medical record review of the Physician Recapitulation orders dated May 1, 2013, revealed resident weights March 2013, 162 LBS(pounds), April 2013, 156 LBS. Continued review of the Recapitulation orders revealed "...February 27, 2013 (original date of order)...Jevity 1.5 CAL (calorie) PEG tube TID (three times a day) PRN (as needed) give if eats less than 25 % of meal..." Medical record review of the resident's Daily Meal Intake Report for March 2013 and April 2013 revealed fifty of sixty days with incomplete documentation of the resident's intake. Medical record review of the resident's Medication Administration Record for March 2013 and April 2013, revealed only seventeen days the Jevity 1.5 cal was documented as administered through the tube. Medical record review of a Dietary assessmnet dated May 22, 2013, revealed "...Resident's eatin (eating) varies. Nausea and vomiting occuring more often..." Interview and medical record review on May 30, 2013, at 1:15 p.m., with the DON confirmed the facility failed to consistently monitor/document the resident's meal intake and administration of the tube feeding.	F 514	Any staff not attending mandatory in-services will not be allowed to work until they have attended the in-service. Effective 6/14/13 the new electronic medication system purchased by facility will go live. The company staff began educational training on 5/13/13 with implementation in June. The new EMR system will not allow nurses to leave blanks on the MAR. It will also be easier to check for documentation of meal percentages. 2) Beginning 6/13/13 the DON & Supervisor checked all resident's chart for any missed documentation on meal percentages and tube feeding and medications not documented. There were no residents with missed meal percentages or missed tube feeding or medication documentation. These checks will be conducted daily for 4 weeks, then randomly on a monthly basis.	

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			3) To ensure the deficient practice does not recur, the DON &/or Supervisor will begin on 6/13/13 checking documentation daily for 4 weeks, then a random sample monthly for any omission of documentation of percentage of meals and documentation of tube feeding & medications. If any errors or omissions are found, the responsible staff member will be notified within 24 hours and required to return to facility to correct the documentation. Continued deficient practice will be disciplined by the DON. Beginning 6/13/13 the Consultant Pharmacist will also monitor for any missed documentation of medications monthly and report to the DON the outcomes of the monitoring. 4) Beginning 6/13/13, the DON will report monitoring outcomes quarterly to QAPI Committee. The next QAPI meeting is scheduled for July 8, 2013. The Administrator will report outcomes at the next Governing Body meeting.	